This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.umr.com or by calling 1-800-826-9781.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** person / **$300** person + one / **$450** family In-network **$300** person / **$600** person + one / **$900** family Out-of-network Copayments do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers..
Is there an out–of–pocket limit on my expenses?	Yes. **$150** person / **$300** person + one / **$450** family In-network **$900** person / **$1,800** person + one / **$2,700** family Out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments for medical services, penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes. **$2,250,000**	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers,** see www.umr.com. Under the UnitedHealthcare Choice Plus Network. You may also call 1-800-826-9781.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay per visit; 100% paid by plan after deductible	$15 Copay per visit 65% paid by plan after deductible	Maximum office visit copays per calendar year 3 for single; 7 for family plan.
	Specialist visit	$15 Copay per visit	$15 Copay per visit	Deductible Waived
	Other practitioner office visit	20% Coinsurance Chiropractic care; No charge Acupuncture	20% Coinsurance Chiropractic care; 35% Coinsurance Acupuncture	$100 Deductible per person and $300 Deductible per family per calendar year Chiropractic care
	Preventive care/screening/ immunization	No charge	35% Coinsurance; No charge Immunizations to age 6	Deductible Waived In-network; Deductible Waived Out-of-network to age 6
If you have a test	Diagnostic test (x-ray, blood work)	No charge	35% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No charge	35% Coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.umr.com.	Generic drugs	$5 Copay per prescription	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Covers up to a 34-day supply (retail and specialty); 35-90 day supply (mail order)
	Preferred brand drugs	$15 Copay per prescription		
	Non-preferred brand drugs	$25 Copay per prescription		
	Specialty drugs	$5 Copay per prescription(generic); $15 Copay per prescription(preferred brand); $25 Copay per prescription(non-preferred brand)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	35% Coinsurance	——————none——————
	Physician/surgeon fees	No charge	35% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	No charge	No charge	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	No charge	No charge	In-network deductible applies to Out-of-network benefits; $2,000 Maximum benefit per trip Ambulance air
	Urgent care	$15 Copay per visit up to a Maximum of 3 visits per person/ 7 visits per family per calendar year; No charge after Maximum	$15 Copay per visit up to a Maximum of 3 visits per person/ 7 visits per family per calendar year; 35% Coinsurance after Maximum	Deductible Waived In-network up to 3 visits per person/7 visits per family per calendar year, then Deductible Applies

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network	Out-of-network	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	35% Coinsurance	Prior authorization is required or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
	Physician/surgeon fee	No charge	35% Coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 Copay per office visit; No charge other outpatient services	$15 Copay per office visit; 35% Coinsurance other outpatient services	Deductible Waived office visit
	Mental/Behavioral health inpatient services	No charge	35% Coinsurance	Prior authorization is required or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
	Substance use disorder outpatient services	$15 Copay per office visit; No charge other outpatient services	$15 Copay per office visit; 35% Coinsurance other outpatient services	Deductible Waived office visit
	Substance use disorder inpatient services	No charge	35% Coinsurance	Prior authorization is required or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
If you are pregnant	Prenatal and postnatal care	No charge	35% Coinsurance	Deductible Waived In-network Prenatal
	Delivery and all inpatient services	No charge	35% Coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	35% Coinsurance	40 Maximum visits per calendar year; Prior authorization is required or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
	Rehabilitation services	No charge	35% Coinsurance	none
	Habilitation services	Not covered	Not covered	none
	Skilled nursing care	No charge	35% Coinsurance	First 30 days Maximum per confinement; there must be a 180 day separation between confinements, before an additional 90 days are covered per confinement; Prior authorization is required or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
	Durable medical equipment	No charge	35% Coinsurance	Prior authorization is required for DME in excess of $500 for rentals or $1,500 for purchases or benefit reduces by 20% to a maximum of $100 per claim Out-of-network
	Hospice service	No charge	35% Coinsurance	none
If your child needs dental or eye care	Eye exam	No charge	35% Coinsurance	Deductible Waived In-network; 1 Maximum exam per calendar year
	Glasses	Not covered	Not covered	none
	Dental check-up	Not covered	Not covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture for anesthesia or pain control
- Chiropractic care
- Hearing aids (Dependents under age 18)
- Non-emergency care when traveling outside the U.S.
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-826-9781. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: UMR at 1-800-826-9781. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

欲将该文件翻译成中文，请联系您的雇主。

Díí naaltsos Dine k'eh saadjį'go háádidool nílgo, éí t'ááshǫǫdí bá nalnishígíí bil hodolnih.

Si necesita este documento traducido al español, comuníquese con su empleador.

Upang ipa-translate ang dokumentong ito sa Tagalog, mangyaring makipag-ugnay sa iyong employer.

This is only a summary. It in no way modifies your benefits as described in your plan documents. Please refer to your plan documents provided by your employer for complete terms of this plan.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $7,300
- Patient pays $240

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$40
Coinsurance	$0
Limits or exclusions	$0
Total	**$190**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,700
- Patient pays $700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Copays	$500
Coinsurance	$0
Limits or exclusions	$0
Total	**$700**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.